PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445479	A. BUILDING 01 - LIFE CARE CENTER OF G B. WING _____	10/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GRAY	791 OLD GRAY STATION ROAD GRAY, TN 37615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure interior room surface finishes had a flame spread rating of C or less. The findings include: Observation and interview with the Maintenance Director in the kitchen stock room, on October 4, 2010 at 11:05 a.m. confirmed the kitchen stock room walls were covered with painted T-11 exterior siding. Record review of the manufacturer's MSDS documentation confirmed it as "FLAMMABLE".	K 015	**K 015 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the deficient practice. Fire wall placed on 10/29/10. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Maintenance director was re-educated on ensuring the interior room surfaces have a flame spread rating of C or less. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** The ED will inspect all interior surface finishes prior to use. Findings of the Audits will be taken to the PI meetings for the 3months beginning with the PI meeting set for November 2nd 2010.	11/2/10
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029	K-029 Corrective Action 10/22/10 **K 029 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected. Penetrations were filled.	11/2/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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K 029	Continued From page 1 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous area ' s one (1) hour fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director in the laundry, on October 4, 2010 at 11:35 a.m. confirmed unsealed penetrations in the following areas: 1) Around the laundry dryer vents penetrating into the attic space 2) in the laundry washer room where plumbing lines penetrated the ceiling. 3) In the 100 hall mechanical room, an insulated refrigerant line for the HVAC duct penetrating the ceiling. Based on observation and interview, the facility failed to assure rooms used to store combustible materials, were provided with self-closing doors. The findings include: Observation and interview with the Maintenance Director on October 4, 2010 at 11:35 a.m.. confirmed the supply room next to room 303, Storage room across from room 303, and laundry corridor doors would not close to a positive latch and were not provided with door closers (NFPA 101, 19.3.2.1 (7).	K 029	**Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Re-educate the maintenance staff on the importance of ensuring penetrations are filledimmediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** The ED will give prior approval before any penetrations are made into the fire wall and will inspect after. Findings of audits will be taken to the PI meeting for the next 3 months. Beginning with the PI meeting set for Nov. 2nd 2010.	11/2/10
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.		**K 076 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the deficient practice. Electrical outlet was immediately disconnected and covered over.	11/2/10 10-4-10

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K 076	Continued From page 2 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure electrical components in medical gas storage locations were located greater than five (5) feet above the floor. (NFPA 99, 4-3.1.1.2 (a)4) The findings include: Observation with the Maintenance Director on October 4, 2010 at 1:30 p.m. confirmed the Oxygen storage room across from the 100 hall Nurses Station, had an electrical outlet located 18-inches above the finished floor.	K 076	**Residents identified as having the potential to be affected by the same deficient practice.** **What corrective actions will be taken?** All residents have a potential to be affected. All O2 storage rooms were inspected no other rooms were found to have deficient practice. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Maintenance director was re-educated on ensuring the medical gas storage room has electrical component greater than 5 feet above floor. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Maintenance Director will get prior approval from the ED for any room which in O2 is being stored. Findings will be taken to the PI committee for the next 3 months. Beginning on Nov. 2nd 2010.	11/2/10 10/22/10 11/2/10
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure extension cords and multiple outlet adapters were not used (NFPA 99, 3-3.2.1.2 (d) (2) states: There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.) ...	K 147	**K 147 NFPA 101 Life Safety Standard SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents in room 109, the power strip was replaced with a 12 gauge. **Residents identified as having the potential to be affected by the same deficient practice.** **What corrective actions will be taken?** All residents have a potential to be affected. All rooms were checked to ensure that no power strips less than 12 gauge were being used.	10/4/10

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K 147	Continued From page 3 The findings include: Observation and interview with the Maintenance Director, on October 4, 2010 at 1:30 p.m. confirmed the resident room 109 had a 14-gauge power strip that was not rated for use with a 12-gauge refrigerator and an Oxygen concentrator was plugged into it.	K 147	**What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Maintenance Staff was re-educated on ensure all power strips are 12 gauge. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Rooms will be inspected monthly to ensure 12gauge power strips are being used. Will be taken to the PI meeting monthly for the next 3 months. Beginning Nov.2 2010.	